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In the Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS

v.

JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether Kentucky's "any willing provider" law, which requires each insurer (including each health maintenance organization) in the State to make available to its insureds the services of any medical provider in its geographical region that agrees to the terms and conditions offered by the insurer, is saved from preemption as a law that "regulates insurance" under Section 514(b)(2)(A) of the Employee Retirement Security Act of 1974, 29 U.S.C. 1144(b)(2)(A).

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INTEREST OF THE UNITED STATES

The Secretary of Labor has primary authority for enforcing and administering Title I of the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. 1001 *et seq.* See 29 U.S.C. 1002(13), 1136(b). The United States filed an amicus brief at the petition stage in response to this Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. The "any willing provider" (AWP) section of Kentucky's Insurance Code provides:

> A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

Ky. Rev. Stat. Ann. § 304.17A-270 (Michie 2001). Under the Insurance Code, the insurer must disclose in writing to

insureds "that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer." *Id.* § 304.17A-505(1)(k).

Other provisions of Kentucky's Insurance Code extensively address the relationship between insurers and health-care providers. Insurers must "establish relevant, objective standards" for providers to participate in their networks, and they must not "use criteria that would allow an insurer to avoid high-risk populations." Ky. Rev. Stat. Ann. § 304.17A-525 (Michie 2001). Insurers must pay claims timely and correctly submitted by providers and publicize the information needed to submit a claim. *Id.* § 304.17A-702. Contracts between insurers and providers must include a number of mandatory clauses, including a "hold harmless" clause that precludes providers from seeking reimbursement from their patients, and a "continuity of care" clause that requires the provider to continue providing care even after termination of the contract under certain conditions. *Id.* § 304.17A-527(1). In addition, a "managed care plan may not contract with a health care provider to limit the provider's disclosure to an enrollee * * * of any information relating to the enrollee's medical condition or treatment options." *Id.* § 304.17A-530(1). See *id.* § 304.17A-515(1) (requiring managed care plans to "arrange for a sufficient number and type of primary care providers and specialists"); *id.* § 304.17A-150 (insurer may not require provider to participate in all of insurer's plans if provider wants only to participate in one).

The Insurance Code defines "insurer" for these purposes as

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Id. § 304.17A-005(23).

2. Petitioners are three health maintenance organizations (HMOs) and an association of HMOs that operate in Kentucky. Pet. Br. ii. As it applies to HMOs, the effect of the AWP provision of Kentucky's Insurance Code is to require an HMO to open its provider network to any qualified physician in the covered geographic area who is willing to abide by the HMO's terms and conditions. The purpose of such AWP laws is to foster patients' freedom to receive medical care from providers of their choice. See Kentucky Br. in Opp. 2 ("In drafting the AWP statutes, the Kentucky General Assembly's clear focus was to regulate insurance and to provide additional benefits to the consumers of Kentucky, many of whom were limited to one choice of insurer in their county or geographic area.").

The question presented in this case is whether ERISA preempts the Kentucky AWP law. The issue arises because ERISA governs employer-provided health plans, the great majority of which are insured or administered by HMOs. Sara Rosenbaum & Brian Kamoie, *Managed Care and Public Health: Conflict and Collaboration*, 30 J.L. Med. & Ethics 191, 192 (2002) ("As of 2000, more than 90 percent of all persons with employer-based health insurance coverage were enrolled in some form of managed care."). Three related components of ERISA's express preemption provision are relevant. First, ERISA's general preemption provision, Section 514(a), 29 U.S.C. 1144(a), states that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Second, Section 514(a) is "substantially" and "broadly" qualified, *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 733 (1985), by a saving clause, which provides that "nothing in this subchapter shall be construed to exempt or

relieve any person from any law of any State *which regulates insurance*, banking, or securities." ERISA Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A) (emphasis added). Third, ERISA's "deemer" clause, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which qualifies the insurance saving clause, provides that "[n]either an employee benefit plan * * * nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer * * * for purposes of any law of any State purporting to regulate insurance companies, [and] insurance contracts."

3. Petitioners filed suit to enjoin respondent from enforcing Kentucky's AWP law, contending that it is preempted by ERISA. Pet. App. 64a-65a. The district court held that, although the law "relate[s] to" ERISA plans, it "regulates insurance" and is therefore saved from preemption under the saving clause. *Id.* at 78a-83a.

4. A divided panel of the Sixth Circuit affirmed. Pet. App. 1a-38a. The court unanimously ruled that Kentucky's AWP law "relate[s] to" employee benefit plans under 29 U.S.C. 1144(a), because it has both a reference to and a connection with ERISA plans. The court concluded that, because the AWP law in terms applies to a self-insurer that is "not exempt from state regulation by ERISA," see Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001), it refers to ERISA plans. See Pet. App. 14a. The court further held that such AWP laws have a connection with ERISA plans because they "affect the benefits available by increasing the potential providers, [and] they directly affect the administration of the plans." *Id.* at 19a.

Like the district court, however, the panel majority ruled that the AWP law is saved from preemption as a law that "regulates insurance." The court first found (Pet. App. 22a-24a) that the AWP law is specifically directed at the insurance industry, thus satisfying the "common-sense" test that this Court has set forth in applying ERISA's insurance saving clause. Indeed, the court found the common-sense

test "clearly" satisfied because the AWP law increases benefits by giving enrollees more freedom to choose and is part of "a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans." Pet. App. 30a.

Following this Court's precedents, the court also considered the three factors utilized in determining whether a particular practice constitutes the "business of insurance" for purposes of the McCarran-Ferguson Act, 15 U.S.C. 1012(b). First, the court concluded that the AWP law "spreads the cost component of the policyholder's risk among all insureds, instead of requiring the policyholder to shoulder all or part of the cost when seeking care or treatment from an excluded doctor or hospital of his or her choice." Pet. App. 31a. Second, the court found that the AWP law "directly impact[s] the insurer-insured relationship because [it] * * * expand[s] covered treatment from a closed pool of providers to an open pool of providers." *Id.* at 36a. Third, the court reiterated that the AWP law is directed at insurance. *Id.* at 36a-37a.

Judge Kennedy dissented from the court's holding that the AWP law "regulates insurance" and is therefore saved from preemption. Pet. App. 39a-63a.

SUMMARY OF ARGUMENT

I. Kentucky's AWP law "relate[s] to" ERISA plans within the meaning of ERISA's preemption clause, 29 U.S.C. 1144(a), "by requiring them to [maintain open-panel provider networks] if they purchase medical coverage from any of the common types of health care organizations covered by the state law's definition of [health insurer]." *Rush Prudential HMO, Inc.* v. *Moran*, 122 S. Ct. 2151, 2159 (2002).

II. The Kentucky law, however, is saved from preemption because it is a law that "regulates insurance" within the meaning of ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). The law regulates insurance as a matter of "common sense" because it is directed at insurers, including HMOs. *Rush*, 122 S. Ct. at 2159-2160. The relevant provi-

sion twice refers to "health insurer[s]" as the object of state regulation, and it is codified in Kentucky's Insurance Code, along with many other regulations of insurers. Furthermore, the AWP law's mandate of open-panel provider networks fundamentally affects the insurer's underlying insurance promise to the insured: it prohibits insurance arrangements in which the insurer essentially agrees to insure against medical costs only if incurred with the insurer's choice of provider, and it instead requires arrangements in which the insurer agrees to insure against medical costs if incurred with any provider who is willing to accept the insurer's fees and qualification standards.

If Kentucky's AWP law is not insurance regulation from a common sense view, the ability of Kentucky (and many other States) to enforce any of the large variety of other laws that regulate the relationship between health insurers of all types and health-care providers will similarly be threatened by ERISA preemption. Petitioners' arguments are thus contrary to this Court's precedents, which have emphasized that ERISA was intended to preserve state law in areas of traditional state regulation such as insurance and health care.

The common sense conclusion that Kentucky's AWP law "regulates insurance" is confirmed by a consideration of the three factors that have been used to determine what constitutes the "business of insurance" under the McCarran-Ferguson Act. First, the AWP law concerns the allocation and spreading of risks in that it addresses the performance of the insurance contract, and without performance "there is no risk transfer at all." *Department of Treasury* v. *Fabe*, 508 U.S. 491, 503-504 (1993). Second, the law affects an integral part of the policy relationship, because it substantially affects the scope of the coverage offered by the insurer. Third, it is limited to entities within the insurance industry.

III. Contrary to petitioners' arguments (Br. 14-27), *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), does not control this case. *Royal Drug* involved an insurer's

agreements with pharmacies to limit its costs, a matter with which the insureds were basically unconcerned. The Kentucky AWP law, by contrast, imposes an obligation only on insurers—to accept any willing and qualified provider into their networks—and it does so in order to affect the very structure of the benefit that will be provided to the insured.

More fundamentally, petitioners' argument is based on the erroneous proposition that the analysis in *Royal Drug* controls the analysis of whether a state law "regulates insurance" under ERISA. This Court has never held that the McCarran-Ferguson factors drawn from *Royal Drug* are dispositive in the ERISA context. Instead, as the primary test under ERISA, the Court has set forth a common-sense inquiry, with the McCarran-Ferguson factors used only as relevant guideposts. Furthermore, *Royal Drug* itself involved a claim of exemption from the antitrust laws under the second clause of Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), which exempts the "business of insurance" from the federal antitrust laws. The Court explained both in *Royal Drug* and in *Fabe* that its analysis in *Royal Drug* was influenced by the well-settled rule that exemptions from the antitrust laws must be narrowly construed. The ERISA analysis, however, is driven by the quite different policy of preserving state authority in areas of traditional state regulation (such as insurance and health care) unless Congress's intent to preempt such authority is clear.

ARGUMENT

I. THE KENTUCKY ANY WILLING PROVIDER LAW "RELATES TO" ERISA PLANS BECAUSE IT HAS A CONNECTION WITH SUCH PLANS

Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Section 514(a) "indicates Congress's intent to establish the regulation of * * * [ERISA] plans as exclu-

sively a federal concern." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (internal quotation marks omitted). Section 514(a) is "clearly expansive" in its preemptive sweep. *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 146 (2001). In general, a state law "relate[s] to" an ERISA plan "if it has a connection with or reference to such a plan." *Id.* at 532 U.S. at 147 (quoting *Shaw* v. *Delta Air Lines*, 463 U.S. 85, 97 (1983)).

The court of appeals erred in holding that the Kentucky AWP law makes a prohibited "reference to" ERISA plans. By its terms, the AWP law applies to any "insurer," including any "self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001) (emphasis added). That reference to the ERISA *statute* neither singles ERISA *plans* out for different treatment as a matter of state law, *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988), nor is dependent on the existence of such plans for its operation, *District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 130-131 (1992); see *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). Rather, the AWP law's reference to ERISA simply gives effect to the restrictions imposed as a matter of federal law by the "deemer clause" of ERISA, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which prevents the States from regulating self-insured ERISA plans under the guise of regulating insurance. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990). Such a reference to ERISA is essentially surplusage, because ERISA's deemer clause would limit the state law's applicability to self-insured ERISA plans in any event. See *Rush Prudential HMO, Inc.* v. *Moran*, 122 S. Ct. 2151, 2162 (2002); *FMC Corp.*, 498 U.S. at 61, 62. It would be perverse —and an affront to federalism—to conclude that a State's express acknowledgment of ERISA's preemptive force would

require preemption of the entire state law that contains that acknowledgment.

The Kentucky AWP law does, however, have a "connection with" ERISA plans sufficient to conclude that it "relates to" such plans within the meaning of Section 514(a). In *Rush*, the Court held it to be "beyond serious dispute" that a state law requiring an HMO to provide independent review of disputes between a patient and the HMO "relates to" ERISA plans because the law forced HMOs to submit to "an extra layer of review for certain benefit denials" under the ERISA plans the HMOs insured. 122 S. Ct. at 2159. The Kentucky AWP law does not have the same sort of direct impact on the actual administration of claims under ERISA plans. And, to be sure, the AWP law does have an effect on providers, who are one step further removed from ERISA plans than are the insurers themselves. But the AWP law *also* has a substantial effect on the coverage that is offered to individuals who are insured under insurance purchased by ERISA plans. The latter effect is sufficient to render the AWP law one that is connected with, and therefore "relates to," ERISA plans.

The AWP law requires HMOs and other insurers to offer open-panel provider networks (*i.e.*, those in which the insurer must include in its roster of available providers any qualified physician willing to abide by its rules), rather than closed-panel networks (*i.e.*, those in which the insurer may limit the providers as it wishes), to all who purchase their policies, including ERISA plans. The consequence is to preclude HMOs from artificially limiting the number of available providers and thus to broaden the range of providers whose services will be covered by insurance under the plan. The impact of the AWP law is not merely an incidental economic one, as in *Travelers*, 514 U.S. at 658-662; *Dillingham*, 519 U.S. at 328-334; *Mackey*, 486 U.S. at 831-836; and *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-816 (1997). Instead, whether viewed from the perspec-

tive of the insured, whose range of options under the insurance policy is broadened, or the insurer, which is precluded from limiting its network of providers, the AWP law "mandate[s] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658; see *Rush*, 122 S. Ct. at 2159. It therefore is most analogous to mandated-benefit laws, which this Court has found relate to ERISA plans. Compare *Metropolitan Life*, 471 U.S. at 739 (assuming that law requiring minimum mental health benefits relates to ERISA plans); *Shaw*, 463 U.S. at 97 (law requiring pregnancy benefits relates to ERISA plans). Thus, like the Illinois law in *Rush*, Kentucky's AWP law has a "connection with" ERISA plans because it "bears 'indirectly but substantially on all insured benefit plans' * * * [that] purchase medical coverage from any of the common types of health care organizations covered by the state law's definition of [health insurer]." *Rush*, 122 S. Ct. at 2159 (quoting *Metropolitan Life*, 471 U.S. at 739).

II. KENTUCKY'S AWP LAW "REGULATES INSURANCE" WITHIN THE MEANING OF ERISA'S INSURANCE SAVING CLAUSE

ERISA's saving clause, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), "reclaims [to the States] a substantial amount of ground" that the basic "relates to" preemption provision in Section 514(a) otherwise would take away. *Rush*, 122 S. Ct. at 2158. The saving clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A). By saving state laws that "regulate[] insurance," Section 514(b)(2)(A) "leaves room for complementary or dual federal and state regulation," *John Hancock Mut. Life Ins. Co.* v. *Harris*, 510 U.S. 86, 98 (1993), and preserves the States' traditional role in insurance regulation. Indeed, construction of the insurance saving clause is informed by the bedrock principle that

"the historic police powers of the States were not meant to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Rush*, 122 S. Ct. at 2159 (quoting *Travelers*, 514 U.S. at 655); *De Buono*, 520 U.S. at 813 n.8 (same); *Metropolitan Life*, 471 U.S. at 740 (saving clause "broadly" preserves State's lawmaking powers).

A. As A Matter Of "Common Sense," Kentucky's AWP Law Regulates Insurance

To determine whether a state law "regulates insurance" and thus is saved from preemption under ERISA, the Court first undertakes a "'common-sense view of the matter' under which a 'law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.'" *Rush*, 122 S. Ct. at 2159 (quoting *Metropolitan Life*, 471 U.S. at 740, and *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 50 (1987)); accord *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 367-368 (1999). A state tort or contract law of general applicability that includes the insurance industry within its reach, but is not specifically directed at it, does not "regulate[] insurance" and therefore is not within the saving clause. *Pilot Life*, 481 U.S. at 50, 57. A state law, however, that "homes in on the insurance industry and does 'not just have an impact on [that] industry'" satisfies the common-sense inquiry. *UNUM*, 526 U.S. at 368 (quoting *Pilot Life*, 481 U.S. at 50).

1. The AWP law satisfies the common-sense inquiry because it is specifically directed at the insurance industry. By its terms, the law applies to "health insurer[s]." Pet. App. 89a. The law defines insurers to include not only traditional health insurers, but also entities that take more innovative approaches to insurance and the provision of health care, such as a "health maintenance organization" and a "provider-sponsored integrated health delivery network." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001); see *Rush*, 122 S. Ct. at 2163. Petitioners concede that HMO-style organiza-

tions are "insurers." Pet. Br. 30; see *Pegram* v. *Herdrich*, 530 U.S. 211, 218-219 (2000); accord *Rush*, 122 S. Ct. at 2160. While nontraditional insurance entities such as HMOs may directly provide health care, they still function as insurers, and the insurance saving clause applies. *Rush*, 122 S. Ct. at 2160, 2163.

Petitioners contend (Br. 31 n.14) that the Kentucky AWP law is not specifically directed at the insurance industry because it applies to *self*-insured government and church medical benefit plans, which are not ERISA plans, see 29 U.S.C. 1003(b). A State, however, may reasonably conclude that "a party who has not purchased insurance, effectively act[s] as its own insurer" in a particular context, and may therefore regulate that self-insuring entity as part of the State's regulation of insurance. Pet. App. 24a; see *General Elec. Co.* v. *Gilbert*, 429 U.S. 125, 138 n.16 (1976) ("That General Electric self-insures does not change the fact that it is, in effect, acting as an insurer."). Indeed, ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B), necessarily presumes that self-insured entities are generally subject to state insurance laws; otherwise, "it would have been unnecessary for the deemer clause explicitly to exempt such laws from the [insurance] saving clause," which, after all, saves only state laws that "regulate[] insurance" in the first place. *Metropolitan Life*, 471 U.S. at 741. In *Metropolitan Life*, this Court held that a state mandated-benefits law regulated "insurance" within the meaning of the saving clause, even though it included self-insured plans among the insurers within its scope. See *id.* at 735-736 n.14, 740-747. The same conclusion follows here.[1]

[1] Petitioners also rely (Br. 31 n.14) on the alleged application of Kentucky's AWP law to the presumably relatively small number of instances in which "HMOs * * * provide only administrative services" to government and church plans. The court of appeals held that the Kentucky law does not apply to such HMOs. Pet. App. 28a n.14. In any event, the Court rejected much the same argument in *Rush*. 122 S. Ct. at 2163.

Petitioners also argue (Br. 27) that the Kentucky law is not specifically directed at the insurance industry as a matter of common sense because it "regulate[s] insurers *and providers*, by barring the latter from entering into limited network contracts with the former." That contention is mistaken. By its terms, the AWP law provides that "[a] *health insurer* shall not discriminate against any provider" who accepts the terms and conditions "established by the health insurer." Ky. Rev. Stat. Ann. § 304.17A-270 (Michie 2001) (emphasis added). Thus, the "specific obligation" of the AWP law falls only upon health insurers. *Rush*, 122 S. Ct. at 2163. As petitioners themselves elsewhere concede (Br. 3), "[t]he purpose and effect of [Kentucky's] AWP laws is to require petitioners and other HMOs to throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts." Providers need not similarly offer to enroll in the network of any health plan that wants their services.

As a result of the AWP law, health-care providers in Kentucky will be unable to find in-state insurers who will guarantee them exclusive contracts (although they may find in-state self-insured ERISA plans that will do so). But that is simply the consequence of the State's decision to regulate this particular aspect of insurers' operations. If that consequence were sufficient to remove a state law from the scope of ERISA's insurance saving clause, then *any* state law regulating *any* aspect of insurers' arrangements with providers would appear to be beyond the scope of the saving clause and, under petitioners' theory, would be preempted under Section 514(a) of ERISA. The consequences of that rule would be far-reaching. As noted above, state insurance law may regulate many aspects of the relationship between health insurers and providers whose services they cover. For example, Kentucky law requires, *inter alia*, timely payment of providers' claims; it requires insurers not to use qualification standards for providers that would screen out

high-risk populations; it requires insurers to include "hold harmless" and "continuity of care" clauses in their contracts; and it precludes provisions that would limit a provider's disclosures to a patient. See p. 2, *supra*. If petitioners' theory were correct, all of those provisions would be in danger of preemption.

2. The AWP law's location within Kentucky's Insurance Code underscores that it is an insurance regulation from a common-sense perspective. This Court has held that that classification is "relevant to the enquiry, because Congress, in leaving the 'business of insurance' to the States, 'was legislating concerning a concept which had taken on its coloration and meaning largely from state law, from state practice, and state usage.'" *Rush*, 122 S. Ct. at 2161 n.5 (quoting *SEC* v. *Variable Annuity*, 359 U.S. 65, 69 (1959)). Accordingly, a State's determination that a particular measure is the regulation of insurance is entitled to respect under ERISA. In this case, Kentucky's AWP law is found in a chapter of its Insurance Code and alongside provisions requiring coverage of, *inter alia*, mammograms, maternity, and diabetes—*i.e.*, alongside the kind of mandated-benefit provisions the Court held to fall within the insurance saving clause in *Metropolitan Life*. See Ky. Rev. Stat. Ann. §§ 304.17A-133, 304.17A-145, 304.17A-148 (Michie 2001). Indeed, the AWP law was enacted as part of a wide-ranging health insurance reform that also included many other laws governing managed care plans. 1998 Ky. Acts 496 §§ 13 (AWP law), 26 (requiring disclosure of terms and conditions of health plan), 27 (requiring, *inter alia*, printed copy of provider directory), 28 (requiring sufficient number of primary care providers and specialists in network), 30 (creating standards for provider participation); see also p. 2, *supra*, (identifying other state laws in same chapter governing provider contracts).

3. The ERISA insurance saving clause protects more than state regulation of the contract between insurer and

insured. See, *e.g.*, *John Hancock*, 510 U.S. at 98 (finding state law concerning management of an insurer's general account assets saved under insurance saving clause); *FMC Corp.*, 498 U.S. at 63 (recognizing the "distinction between *insurers of plans* and the contracts of those insurers, which are subject to direct state regulation" by virtue of insurance saving clause, and self-insurers, "which are not") (emphasis added). Nonetheless, the AWP law's important effect on the contractual arrangement between insurer and insured supports the conclusion that it "regulates insurance."

The AWP law's effect on the basic insurance contract is most clearly illustrated by the provision of Kentucky law that requires insurers to inform enrollees of the operation of the AWP law; the insurer must disclose "in writing *to a covered person and an insured or enrollee* * * * that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer." Ky. Rev. Stat. Ann. § 304.17A-505(1)(k) (Michie 2001) (emphasis added). The purpose of the notice obviously is not merely to inform the insured of some irrelevant business practice engaged in by the insurer. Instead, the notice is based on a recognition that the AWP law bears directly on the scope of the insurance policy: if the insured can convince a provider to become a member of the insurer's network, the insurer must provide coverage under the insurance policy for services furnished by that provider. Moreover, the notice provision reflects the reality that many insureds' primary concern in choosing an insurer is whether the family doctor is a covered provider. Petitioners accordingly are mistaken in asserting (Pet. 29) that "AWP laws concededly do *not* alter, regulate or affect the terms of insurance policies." The Kentucky AWP law was intended to—and does—directly affect the terms of the relationship between insurer and insured.

More generally, petitioners err in contending that the AWP law "simply do[es] not relate to *any* question of what risks of loss are covered or how widely they are spread" (Br. 25) and that the AWP law "regulate[s] an HMO practice * * * that is *not* an 'insurance practice'" (Br. 30-31). The AWP law in fact has a crucial bearing on the scope of the insurance offered and the coverage of risks. Without the AWP law, an HMO would be free to offer a health insurance policy that in effect contained a term under which the costs of medical services are covered only if the insured obtained those services from specific providers. Under the AWP law, however, a health insurance policy must in effect contain a term under which the costs of medical services are covered as long as the insured obtains the services from any provider who complies with the insurer's fee structure and qualification requirements. The first policy contains a restriction on the payment or furnishing of medical service for a covered risk that the second does not.

There is a difference of opinion about which type of policy is better from a social-policy perspective.[2] And in some cases, there may be little difference in practice between the two types of coverage—where, for example, the insured's provider of choice would have been selected by the HMO in any event, or does not want to provide service on the HMO's

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[2] While AWP laws are enacted to promote freedom of provider choice for patients and may make it easier for patients to shift from one plan to another, critics of such laws contend that they unduly interfere with the ability of HMOs and other insurers to negotiate discounted fees from providers, who can be promised a higher volume of patients if the network is kept limited. See Pet. App. 34a n.18 (citing James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Cumb. L. Rev. 199, 210 (1996-1997)); see also Briefs of Amici American Association of Health Plans, Inc., and Society for Human Resource Management. Those policy issues have no bearing on the question whether the Kentucky AWP law is preempted by ERISA. See *Pegram* at 530 U.S. 221 ("[S]uch complicated factfinding and such a debatable social judgment are not wisely required of courts.").

terms. But there can be no question that the two types of coverage may be quite different—where, for example, an insured has moved from one plan to another and wants to continue to use the services of a particular provider who is willing but unable to join the new plan. The two types of coverage are therefore surely distinct, just as each is in turn distinct from standard indemnity insurance, which traditionally insures risks regardless of which provider the insured chooses to use. The AWP law thus addresses an important aspect of the scope of coverage and a condition on payment by a health insurer.

Finally, petitioners' contention (Br. 26) that an HMO's contracts with providers are exclusively concerned with the HMO's furnishing of health care, and do not concern the HMO's furnishing of insurance, is incorrect. Given the complex relations between those two aspects of an HMO, it may be impossible to draw a clear distinction between them for present purposes. See *Rush*, 122 S. Ct. at 2161 (noting that a "dominant feature [of HMOs] is the combination of insurer and provider," and that "[a] common characteristic" of HMO-like entities in recent years is "the degree to which the roles of insurer and provider became integrated"); cf. *Pegram*, 530 U.S. at 228-229 (many, if not most, HMO eligibility and treatment decisions cannot be untangled). But "[n]othing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, and as long as providing insurance fairly accounts for the application of state law, the saving clause may apply." *Rush*, 122 S. Ct. at 2160. Providing insurance "fairly accounts" for the application of Kentucky's AWP law in this case.

Indeed, the identical issue in this case could arise in the context of indemnity insurance, in which the insurer has no obligation to provide health care at all. In the absence of the AWP law, an indemnity insurer could offer to indemnify an insured against medical costs for services provided by a single provider or a set list of providers. Such a policy would

provide a different scope of coverage than a policy that offers (as the AWP law requires) to indemnify an insured against medical costs for services provided by any provider who satisfies certain cost and qualification standards. It would also provide a different scope of coverage than a policy offering to indemnify an insured against medical costs for services provided by any provider at all. A State's decision to require one of those distinct forms of coverage in the context of pure indemnity insurance would unambiguously involve the regulation of insurance. It follows that a State's decision to regulate an HMO's decision to offer one or the other of those types of policies is equally a law that "regulates insurance" within the meaning of ERISA's insurance saving clause. It would, moreover, be contrary to this Court's repeated recognition that the regulation of health care is left to the States under ERISA to conclude that the AWP law, as applied to HMOs, is not saved from preemption as a law that "regulates insurance" offered by HMOs because the AWP law also affects the furnishing of health care by HMOs.

B. Consideration Of The McCarran-Ferguson Factors, As Applicable In The ERISA Context, Confirms That Kentucky's AWP Law Is Covered By ERISA's Insurance Saving Clause

After analyzing a state law as a matter of common sense, the Court "then test[s] the results of the common-sense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*" *Rush*, 122 S. Ct. at 2159. In the ERISA context, those three factors—(1) whether the law transfers or spreads the policyholder's risk, (2) whether the law affects an integral part of the policy relationship, and (3) whether the law is limited to entities within the insurance industry—are helpful "guideposts, not separate essential elements . . . that must each be satisfied

to save the State's law." *UNUM*, 526 U.S. at 374 (internal quotation marks omitted); see *Rush*, 122 S. Ct. at 2163. In this case, those guideposts confirm the conclusion that the Kentucky AWP law "regulates insurance."

1. The court of appeals ruled that the AWP law satisfies the first, risk-spreading factor under ERISA because it has the effect of spreading the insureds' risk by providing them with more physicians to choose from and thereby reducing the likelihood that they will receive medical care outside the network and personally shoulder the cost of treatment. Pet. App. 31a; accord *Stuart Circle Hosp. Corp.* v. *Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.), cert. denied, 510 U.S. 1003 (1993); see *Express Scripts, Inc.* v. *Wenzel*, 262 F.3d 829, 838 (8th Cir. 2001); *Texas Pharmacy Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1041 (5th Cir.), cert. denied, 522 U.S. 820 (1997); *Blue Cross & Blue Shield* v. *Bell*, 798 F.2d 1331, 1334-1335 (10th Cir. 1986).

More fundamentally, in the context of the preemption of a state law under the McCarran-Ferguson Act, a law affecting the *performance* of an insurance contract satisfies the risk-spreading factor, because "[w]ithout performance of the insurance policy, there is no risk transfer at all." *Fabe*, 508 U.S. at 503-504. Here, the Kentucky AWP law addresses the performance of insurance policies by removing a condition on the payment of the costs of treatment for a covered risk—namely, the condition that the treatment will be covered only if it is furnished by a provider who has been selected by the insurer to be a member of its closed network.[3]

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[3] Looked at in another way, for many HMOs, performance of the insurance contract is accomplished by furnishing medical services in kind through providers in the HMO's network, rather than by monetary payments to indemnify the insured for costs incurred in receiving services from any provider chosen by the insured. The Kentucky AWP law regulates the performance of the insurance contract by such HMOs by specifying which providers' services may be furnished in kind in fulfillment of the HMO's insurance obligation.

2. As the court of appeals correctly concluded, Pet. App. 35a-36a, the AWP law also "serves as 'an integral part of the policy relationship between the insurer and the insured.'" *UNUM*, 526 U.S. at 374 (quoting *Metropolitan Life*, 471 U.S. at 743); see also Pet. App. 36a; *Stuart Circle*, 995 F.2d at 503. Like other mandated-benefit provisions, the AWP law's mandate of open networks fundamentally changes the underlying insurance promise between the insurer and insured. See *Metropolitan Life*, 471 U.S. at 744 (state regulation affecting "*the type of policy which could be issued*" is part of "the core of the 'business of insurance'") (emphasis added); see also *UNUM*, 526 U.S. at 374 (notice-prejudice rule integral to relationship by changing bargain between insurer and insured); *Texas Pharmacy Ass'n*, 105 F.3d at 1041. The AWP law, although not mandating coverage of a specific condition (as in *Metropolitan Life*), nevertheless defines the scope of the benefits provided and mandates the type of policy that may be issued. See *Fabe*, 508 U.S. at 501 (McCarran-Ferguson Act applies to statutes that "directly or indirectly" regulate insured-insurer relationship) (quoting *SEC* v. *National Secs., Inc.*, 393 U.S. 453, 460 (1969)). Moreover, for many insureds, knowing whose services are covered is as important a part of the insurer-insured relationship as knowing which services are covered. Indeed, petitioners' own contention that AWP laws make it difficult for HMOs to limit the number of providers in their networks necessarily implies that AWP laws make it likely that insureds will enjoy greater choice in selecting providers.

The significance of the provider network to HMO health insurance cannot be overstated. HMOs determine who provides health care to their members. A member may not obtain health care from providers outside the network and expect the HMO to pay for it, unless the policy specifically

contains that benefit.[4] Thus, the provider network—the totality of provider contracts—fundamentally defines the HMO's insurance obligation to the insured, and AWP laws, by affecting provider networks, in turn affect the insurance provided by HMOs. See *UNUM*, 526 U.S. at 374-375; see also Pet. App. 23a; *Express Scripts*, 262 F.3d at 837-838; *Texas Pharmacy Ass'n*, 105 F.3d at 1041.

3. For essentially the same reasons that the AWP law regulates insurance as a matter of common sense, see pp. 11-18, *supra*, the court of appeals correctly held that the law satisfies the third McCarran-Ferguson factor. The AWP law is "aimed at" the insurance industry, *UNUM*, 526 U.S. at 375 (quoting *FMC Corp.*, 498 U.S. at 61)—*i.e.*, at insurers and entities acting as insurers. Accord *Rush*, 122 S. Ct. at 2164 (third factor requires the targets of the law to be "limited to entities within the insurance industry"). Under any construction, the AWP law has no application outside the context of insurance; it is not a law of broad or general application that happens to include health insurers within its reach. Compare *UNUM*, 526 U.S. at 368-373, with *Pilot Life*, 481 U.S. at 50-51.

4. For the reasons given above, the common-sense test, as well as the three McCarran-Ferguson Act "guideposts," are satisfied in this case. *UNUM*, 526 U.S. at 374. At the very least, the aggregation of the considerations relevant under the three interrelated factors drawn from McCarran-Ferguson Act cases confirms what is evident as a matter of common sense—that a state law that regulates which providers' services will be eligible for coverage under an insurance policy is saved as a law that "regulates insurance."

III. *ROYAL DRUG* DOES NOT CONTROL THIS CASE

Petitioners base essentially all of their argument on the proposition that this Court has already resolved the question

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[4] Kentucky requires HMOs to offer out-of-network benefits under certain conditions. Ky. Rev. Stat. Ann. § 304.17A-550 (Michie 2001).

presented in this case in *Royal Drug*. See Pet. Br. 14-26. Petitioners' argument, however, both ignores the critical distinctions between this case and *Royal Drug*, and rests on a misunderstanding of the appropriate analysis under ERISA's insurance saving clause.

A. The Subject Of The Legal Inquiry In *Royal Drug* Was Distinct From The Subject Of The Inquiry Here

Royal Drug involved an arrangement between an indemnity insurer and pharmacies, under which the insurer agreed to reimburse pharmacies for their costs of drugs to be provided to insureds, so long as the pharmacies charged the insureds only two dollars per prescription. Although the insurer offered that arrangement to all pharmacies, not all pharmacies chose to participate on those terms. 440 U.S. at 209. This Court held that the agreements were not exempt from the federal antitrust laws under Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), based on several considerations that were later crystallized in *Pireno* "as three characteristics of the business of insurance that Congress intended to exempt" from the antitrust laws. *Union Labor Life Insur. Co.* v. *Pireno*, 458 U.S. 119, 127 (1982). *Royal Drug* differed substantially from this case in at least two respects of significance to the ERISA insurance saving clause analysis.

First, in contrast to the private agreements at issue in *Royal Drug*, state AWP laws do not merely set the rate at which an insurer will reimburse a provider who is already a member of the insurer's provider network—a matter with which policyholders are "basically unconcerned." 440 U.S. at 214; see also *Pireno*, 458 U.S. at 132 (policyholder's "only concern is whether his claim is paid"). AWP laws regulate who may be included in the network at all, *i.e.*, which doctors and other providers are available to an insured. Pet. App. 32a. That is a matter in which policyholders are likely to have a keen interest. The Kentucky AWP law regards in-

sureds as directly affected by—and greatly interested in—its mandates and for that reason requires that insureds be directly notified of them by the insurer. Cf. *Rush*, 122 S. Ct. at 2163-2164 (distinguishing state law giving a right to independent medical review to obtain a binding determination on a claim, from an insurer's voluntary use of a peer review committee to assist it in making initial claims determinations, which was "no concern of the insured").

Second, the subject of the legal inquiry in *Royal Drug* was a voluntary practice adopted by the insurer in its contractual arrangements with pharmacies, and the question was whether those *private agreements* between the insurer and providers outside the insurance industry were exempt from the federal antitrust laws as part of the private "business of insurance." See 440 U.S. at 207. The Court concluded that they were not, reasoning, *inter alia*, that an entity that is exempt from the antitrust laws ordinarily forfeits its immunity "by acting in concert with nonexempt parties." *Id.* at 231; accord *Pireno*, 458 U.S. at 133; *Fabe*, 508 U.S. at 503.

By contrast, the subject of the legal inquiry in this case under ERISA's insurance saving clause is a *state law*, not private agreements. And as explained above, (see p. 13, *supra*), the state AWP law imposes an obligation only on insurers. The state law does not impose any obligation on providers. Nor does it purport to exempt any private agreements between insurers and providers from the federal antitrust laws. In sum, there is a substantial difference between the question whether a private agreement between an insurer and providers is exempted from the antitrust laws and the question whether a state law directed at insurance is preempted by ERISA.

B. The McCarran-Ferguson Act Analysis In *Royal Drug* May Inform, But Does Not Control, The ERISA Insurance Saving Clause Analysis

1. From its first decision construing the ERISA insurance saving clause in *Metropolitan Life*, this Court has never suggested that the McCarran-Ferguson Act analysis, as applied in *Royal Drug* or other cases, controls the application of the ERISA clause. In *Metropolitan Life* itself, the Court began with a "common-sense view" of what constitutes a law that "regulates insurance" under the ERISA clause. 471 U.S. at 740-742. Only after concluding that the state mandated-benefits law in *Metropolitan Life* constituted a regulation of insurance within the ordinary meanings of those terms did the Court go on to consider the McCarran-Ferguson factors. Even then, the Court did not hold that the analysis applied in the *Royal Drug* context is necessary to determine the applicability of the ERISA clause.

Petitioners' theory that the McCarran-Ferguson factors as applied in *Royal Drug* are dispositive in the ERISA context is inconsistent with *Metropolitan Life*. Had the Court agreed with petitioners' theory, the Court would have had no need to construct and apply a "common-sense" inquiry for use in ERISA insurance saving clause cases, either in *Metropolitan Life* or in succeeding cases. See, *e.g.*, *Rush*, 122 S. Ct. at 2163-2164; *UNUM*, 525 U.S. at 373-375; *Pilot Life*, 481 U.S. at 50-51. Indeed, while the Court has treated the McCarran-Ferguson factors as guideposts that confirm the conclusion reached by the common-sense test, it has never found a state law to regulate insurance under ERISA as a matter of common sense, but then not as a matter of law, based on an application of factors drawn from that *different* (and differently worded) statute.

2. This Court's use of the McCarran-Ferguson factors in ERISA cases confirms their complementary role in informing the common-sense test. The Court has referred to the

McCarran-Ferguson factors as "guides" or "considerations [to be] weighed," *Pilot Life*, 481 U.S. at 48, or as "guideposts," *Rush*, 122 S. Ct. at 2163, and has stated that they are "criteria relevant to" the ERISA inquiry, *Metropolitan Life*, 471 U.S. at 743. See *UNUM*, 526 U.S. at 373 ("[W]e called the * * * factors 'relevant'; we did not describe them as 'required.'"). Indeed, in two cases, the Court has found state laws to be regulations of insurance under the ERISA saving clause without mentioning the McCarran-Ferguson factors: *FMC Corp.*, in which the Court found a state anti-subrogation provision to be a law that regulates insurance, see 498 U.S. at 61, and *John Hancock*, in which the Court found a state law concerning management of an insurer's general account assets to be a law that regulates insurance, see 510 U.S. at 99. Thus, both the manner in which this Court has considered the McCarran-Ferguson factors in the ERISA context, and the Court's failure to consider them in other ERISA insurance saving clause cases, belie petitioners' argument that the McCarran-Ferguson factors control the application of the ERISA insurance saving clause.

3. There is good reason for the McCarran-Ferguson factors—especially as applied in *Royal Drug*—to play a distinctly secondary role in the ERISA context. Although the ERISA insurance saving clause has wording that is "similar[]" to that of the McCarran-Ferguson Act, *Metropolitan Life*, 471 U.S. at 744 n.21, it is not identical. The ERISA clause saves any state law "which regulates * * * insurance." 29 U.S.C. 1144(b)(2)(A). Section 2(b) of the McCarran-Ferguson Act has two relevant clauses, one of which saves any state law "enacted * * * for the purpose of regulating the business of insurance," and the other of which adds the proviso that the federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. 1012(b). Thus, while the ERISA clause broadly saves laws that regulate "insurance," the McCarran-Ferguson Act

applies in accordance with the more limited term "business of insurance." This Court has carefully parsed the term "business of insurance," *Hartford Fire Ins. Co.* v. *California*, 509 U.S. 764, 781 (1993), distinguishing it from the "business of insurance companies," *ibid.*; *SEC* v. *National Secs. Inc.*, 393 U.S. at 459-460, and holding that not everything an insurance company does is within the "business of insurance." *Royal Drug*, 440 U.S. at 211. By its terms, the ERISA saving clause saves the regulation of "insurance" more generally. The difference in language alone indicates that the ERISA saving clause and the McCarran-Ferguson Act have different scopes. Moreover, nothing in the legislative history of ERISA suggests that Congress intended the ERISA and McCarran-Ferguson language to be construed identically.

4. The special context in which the McCarran-Ferguson factors were applied in *Royal Drug* further demonstrates that that application cannot simply be imported categorically into the ERISA context. Rather, factors that originated in the context of an exemption from the antitrust laws under the McCarran-Ferguson Act can be considered under the insurance saving clause only "'*mutatis mutandis*,' *i.e.*, '[a]ll necessary changes having been made," *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 17 (2000) (quoting *Black's Law Dictionary* 1039 (7th ed. 1999)), to take account of the quite different statutory framework and policies of ERISA.

As the Court in both *Fabe* and *Royal Drug* itself explained, *Royal Drug* involved the *second* clause of Section 2(b), which accomplishes Congress' "secondary goal" in enacting the McCarran-Ferguson Act, which was to carve out only a *narrow* exemption for 'the business of insurance' from the federal antitrust laws." *Fabe*, 508 U.S. at 505 (emphasis added); see *Royal Drug*, 440 U.S. at 218 n.18. In *Royal Drug* itself, this Court emphasized that it was therefore applying the "well settled" principle that "exemptions from the antitrust laws are to be narrowly construed." *Id.* at 205. Accord

Pireno, 458 U.S. at 126; *Abbott Labs.* v. *Portland Retail Druggists Ass'n*, 425 U.S. 1, 11-12 (1976); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973); *United States* v. *McKesson & Robbins, Inc.*, 351 U.S. 305, 316 (1956). By contrast, the *first* clause of Section 2(b) of the McCarran-Ferguson Act, which saves state laws "enacted for the purpose of regulating the business of insurance," "was intended to further Congress's primary objective of granting the States *broad* regulatory authority over the business of insurance." *Fabe*, 508 U.S. at 505 (emphasis added); cf. 15 U.S.C. 1011 (declaration of policy of McCarran-Ferguson Act that "continued regulation and taxation by the States of the business of insurance is in the public interest"). Accordingly, this Court in *Fabe* construed the first clause of Section 2(b) expansively and made clear that the relevant analysis is more flexible than in *Royal Drug* and *Pireno*, in order to achieve Congress's purpose of broadly saving state law in an area of traditional state regulation. 508 U.S. at 500-501, 504-505.

In short, the analysis in *Royal Drug* was expressly influenced by a narrow construction rule and the policy considerations underlying it—a rule and policy that the Court in *Royal Drug* and *Fabe* made clear has no application in the context of the first clause of Section 2(b) at issue in *Fabe*. In *Fabe*, the policy against displacement of traditional state regulatory authority, rather than the policy favoring a narrow construction of antitrust exemptions, was in play. Indeed, in *Royal Drug* itself, the Court strongly suggested that, although the agreements between insurers and pharmacies in that case fell outside the narrow exemption from the federal antitrust laws in the second clause of Section 2(b) of the McCarran-Ferguson Act, those agreements could be regulated by state law in accordance with the first clause of Section 2(b). See 440 U.S. at 218 n.18.

The ERISA insurance saving clause implicates the policies underlying *Fabe* (the preservation of state law) rather than those implicated in *Royal Drug* (the narrow construc-

ton of antitrust exemptions). The ERISA insurance saving clause was designed "broadly to preserve the States' law-making power," *Metropolitan Life*, 471 U.S. at 740, and thereby "reclaim a substantial amount of ground" for state regulation, *Rush*, 122 S. Ct. at 2158. Indeed, this Court in recent years has repeatedly emphasized that under ERISA there is a "starting presumption that Congress does not intend to supplant state law," which is of particular strength "in fields of traditional state regulation" such as insurance and health care. *Travelers*, 514 U.S. at 654, 655; *De Buono*, 520 U.S. at 813 & n.8; *Dillingham* 519 U.S. at 325. ERISA's saving clause thus serves the same basic policies as the law in *Fabe*, and markedly different policies than those involved in *Royal Drug*. In fact, the conclusion that *Royal Drug* does not control the analysis under ERISA follows *a fortiori* from *Fabe*, because, as noted, ERISA saves a broader class of state laws (all those that "regulate[] insurance") than does the first clause of Section 2(b) of the McCarran-Ferguson Act (which saves state laws enacted for the "purpose of regulating the *business* of insurance," 15 U.S.C. 1012(b) (emphasis added).

C. Petitioners' Own Arguments, If Accepted, Would Establish That The AWP Law Is Not Preempted Because It Does Not "Relate To" ERISA Plans To Begin With

Petitioners' reliance on *Royal Drug* in arguing that the Kentucky AWP law is preempted fails for another reason as well. Petitioners take the position (Br. 12), with which we agree, that the AWP law relates to ERISA plans under Section 514(a) because it "affect[s] both plan administration and plan benefits." But petitioners then argue (Br. 20) that AWP laws solely regulate the business practices of HMOs and their relationships with providers, who are one step further removed from ERISA plans than insurers, and that AWP laws therefore do "not alter, regulate or affect the terms of insurance policies." See also Pet. Br. 25 ("[T]he

particular nature of the arrangements with providers the HMO makes—whether they are on a limited basis or not—are immaterial to" the HMO's "obligation to provide care."). In petitioners' view, AWP laws simply prohibit arrangements used by HMOs to minimize their own costs. The structure of a provider's network—whether open or closed—has only a "speculative, marginal" effect on the individuals it insures (Pet. Br. 34) and is not a matter of legitimate concern to them.

If petitioners' later contentions were correct, then petitioners' initial premise—that AWP laws "relate to" ERISA plans in the first place—would be incorrect. Under petitioners' reasoning, AWP laws would have no more effect on ERISA plans than many other contracting practices involving third parties that an HMO might engage in to control its costs. This Court has held that such mere "indirect economic effect[s]" on an ERISA plan are insufficient to warrant a finding that the law imposing those effects "relates to" the plan within the meaning of Section 514(a). See *Travelers*, 514 U.S. at 662. That is especially true where "relates to" preemption would "displace general health care regulation which historically has been a matter of local concern." *Id.* at 661. See *id.* at 663; *De Buono*, 520 U.S. at 815-816. Cf. *Metropolitan Life*, 471 U.S. at 741 ("[L]aws that regulate only the insurer, or the way in which it may sell insurance," and do not regulate the "substantive terms of insurance contracts," "do not 'relate to' benefit plans in the first instance.").

In short, petitioners' core argument under the insurance saving clause is that AWP laws have little or nothing to do with the provision of insurance to ERISA plans. If so, the same argument would establish that AWP laws have little or nothing to do with ERISA plans and are therefore not subject to "relates to" preemption under Section 514(a). Petitioners cannot have it both ways, arguing that the Kentucky AWP law is both so closely connected to an ERISA plan

because of its impact on plan benefits that it "relates to" ERISA plans for purposes of ERISA's principal preemption provision, *and* that its operation is so distant from the relationship between an insurer and ERISA plans and their insured members that it does not even constitute a law that "regulates insurance."

The tension between the "relate[s] to" clause and the insurance saving clause created by petitioner's argument is best resolved by recognizing that *Royal Drug* was quite distinguishable from this case with respect to both the subject of the case and the federal statutory provision under which it arose (a narrow exemption from the federal antitrust laws rather than a broad preservation of state laws regulating insurance). Kentucky's AWP law affects both the type of insurance policy that may be issued to ERISA plans and the benefits received by plan members who are insured under the policy. It therefore relates to ERISA plans, but is saved from preemption as a law regulating insurance.

CONCLUSION

The judgment of the Sixth Circuit should be affirmed.

Respectfully submitted.

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* The Solicitor General is recused in this case.